

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 1 — 0 2 1

2. STATE:

GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

~~XXXXXXXXXX~~ April 1, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

Section 4713(a) of OBRA 1990 Amendment to
1902(a)(10)(F) of the Social Security Act

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 173,021

b. FFY 2002 \$ 513,933

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

ATTACHMENT 2.2-A p. 23a

SUPPLEMENT 11 TO ATTACHMENT 2.6-A,
PAGE 19. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

ATTACHMENT 2.2-A p. 23a

NEW

10. SUBJECT OF AMENDMENT:

COBRA COVERAGE CONTINUATION

GOVERNOR'S REVIEW (Check One):

- ☐
- GOVERNOR'S OFFICE REPORTED NO COMMENT
-
- ☐
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
-
- ☐
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Mark Trail

14. TITLE:

Acting Director, Division of Medical Assistance

15. DATE SUBMITTED:

June 26, 2001

16. RETURN TO:

Georgia Community Health
Division of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

June 29, 2001

18. DATE APPROVED:

August 8, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

April 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Eugene A. Grasser

22. TITLE:

Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

OMB No.:

State/Territory: GEORGIA

Citation(s)	Groups Covered
	B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)
1906 of the Act	<u>X</u> 18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of <u>3</u> months.
1902(a)(10)(F) and 1902(u)(1) of the Act	<u>X</u> 19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditure for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

TN No. 01-021

Supersedes Approval Date AUG 08 2001 Effective Date APR 01 2001

TN No. 94-009

State/Territory: GEORGIA

Citation

Condition or Requirement

**COST EFFECTIVENESS METHODOLOGY FOR
COBRA CONTINUATION BENEFICIARIES**

1902(u) of the
Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

- ☒ X The methodology as described in SMM section 3598.
- ☐ Another cost-effective methodology as described below.

TN No. 01 021

Supersedes
TN No. New

Approval Date AUG 08 2001

Effective Date APR 01 2001